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ORIGINAL ARTICLE

How patients perceive the relationship between trauma, substance abuse, craving, and relapse: A qualitative study

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Abstract

In this qualitative study, patients with comorbid substance use disorder (SUD) and post-traumatic stress disorder (PTSD) were interviewed on their ideas about the link between SUD and PTSD. Although they clearly reported self-medication, they also gave a more complex description of how they believe their PTSD influences their SUD. The results suggest that SUD/PTSD patients believe they did not start using substances because of their experienced traumas or PTSD, but that PTSD symptoms are nonetheless important in the maintenance of their addictions. A clear link exists between craving, relapse, and PTSD symptoms. SUD/PTSD patients would prefer a “whole-person approach” when being treated for their PTSD. It is suggested that the integration of skills training and attention for patients who are fearful of PTSD treatment might improve SUD/PTSD treatment results.

Keywords

Addiction, post-traumatic stress disorder, qualitative

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Introduction

LaCoursiere et al. (1980) were probably the first authors to describe the link between substance use disorder (SUD) and post-traumatic stress disorder (PTSD). Starting in the early 1980s, many authors published articles that described the heightened prevalence of PTSD and trauma exposure among SUD patients and emphasized the vulnerability of this patient subgroup (Bonin et al., 2000; Gielen et al., 2012; Ouimette et al., 1998; Taber et al., 1987).

Recent years have seen the publication of review articles that once again emphasize the need to treat SUD and PTSD in a simultaneous and integrated manner (Dass-Brailsford & Myrick, 2010; Torchalla et al., 2012; van Dam et al., 2012). Despite that recommendation, addiction treatment facilities still do not seem to offer integrated treatment for SUD/PTSD patients (Gielen et al., 2014; Young et al., 2005). Why does this gap between science and clinical practice exist? And, even more importantly, what should be done to bridge this gap?

It is relevant to learn more about how SUD/PTSD patients perceive the link between their traumatic pasts and their SUD. How do patients feel about receiving integrated SUD/PTSD treatment? It is clear from previous studies that we can learn a lot about the relationship between trauma exposure and

addiction by listening to patients' narratives (Larrabee & Bolden, 2001; Sofaer & Firminger, 2005).

Some researchers have queried the views of SUD patients with a traumatic past. For example, the perceptions of patients who suffered sexual abuse as children and now have SUD have been the focus of a qualitative study by Jarvis et al. (1998) and a case study by Teusch (2001). Both research teams noted the important role of self-medication and coping for SUD patients with comorbid PTSD, and both emphasized the complexity of this subgroup of patients. They noted that feelings of impaired self-esteem, hopelessness, shame, and guilt were possible barriers to PTSD treatment.

Hall (2000) and Harris et al. (2005) conducted qualitative studies that only included traumatized women with SUD. Hall interviewed 20 women who had been abused as children and concluded that the abuse was relevant to their current life difficulties. Negative ideas about self and the future were manifested as possible barriers for treatment. The study by Harris et al. focused on recovery and relapse prevention. They stressed the importance of interpersonal connectedness to sustaining an abstinent lifestyle. This study found that depression and a lack of personal control were possible barriers to successful treatment of these patients.

We recently conducted a survey study in which we asked SUD patients with traumatic pasts about how they perceive the interrelatedness between their traumatic pasts and SUD (Gielen et al., 2015). This study included 72 SUD patients with different levels of PTSD severity. We found that the SUD patients with severe PTSD used substances to cope with general stress and had less adequate coping skills than SUD patients with less severe PTSD. Furthermore, this study found that SUD/PTSD patients perceive a clear link between their past traumas and previous relapse experiences.

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Some questions still remain unanswered. Not much is known about what patients actually expect or prefer during their treatment (Dass-Brailsford & Myrick, 2010). Furthermore, patient surveys and interviews have shown that while some patients favor integrated treatment, other patients mainly mention obstacles and barriers related to PTSD treatment during their SUD treatment (Brown et al., 1998; Hall, 2000; Harris et al., 2005; Janikowski et al., 1997; Janikowski & Glover, 1994; Jarvis et al., 1998; Teusch, 2001). It is not clear what determines this distinction. Furthermore, although previous studies have found that SUD/PTSD patients perceive a link between their past traumas and their SUD (Brown et al., 1998; Gielen et al., 2015; Janikowski et al., 1997; Janikowski & Glover, 1994), we have no in-depth understanding of how SUD/PTSD patients evaluate the role of PTSD in the development and continuation of their substance dependency. Do patients think PTSD was involved in the onset of their drug use, the transition into an addiction or the continuation of the addiction and relapses? These missing factors could be important to the successful implementation of integrated SUD/PTSD treatment.

We determined that a qualitative research design was most suitable to reach this in-depth understanding of the perceptions of SUD/PTSD patients. We then formulated two research questions: (1) According to SUD/PTSD patients, why did they start using drugs/alcohol and why did they keep using the substance? and (2) What types of treatment would SUD/PTSD patients prefer and why? To help answer these questions, an independent researcher conducted semi-structured interviews with SUD/PTSD patients.

Material and methods

Data collection and sampling

We recruited 432 SUD patients for a prevalence study. These patients were all in treatment for SUD and were asked to fill out a PTSD questionnaire; 36.6% of them had a positive diagnosis for PTSD (Gielen et al., 2012). From this group, we selected 10 patients using the following selection criteria: main product (i.e., previously preferred psychotropic substance for misuse), age, and treatment facility. This purposeful sampling strategy was used to achieve a heterogeneous sample of treatment-seeking SUD/PTSD patients with differing characteristics. One patient was excluded from further analysis because that patient showed psychotic symptoms during the interview. All interviewed patients had experienced type II trauma with multiple, prolonged, or chronic traumas happening throughout their lives; these included emotional neglect/abuse, sexual abuse, physical abuse, imprisonment, and/or being confronted by or witnessing death. Most patients had experienced a traumatic event in their childhoods and started using drugs and/or alcohol as teenagers.

The SUD/PTSD patients interviewed by us experienced many current complaints and problems. Most of them stated that their problems had already started in childhood. They went on to experience difficulties in their relationships and their families. Some had legal problems and others reported problems related to their social environments and their

Table 1. Sample characteristics.

	Gender	Preferred substance	Age	Treatment facility
1	Male	Poly	36	AT
2	Female	Poly	49	DDW
3	Male	Alcohol	64	OT
4	Male	Poly	29	RT
5	Male	Poly	37	FPAC
6	Male	Poly	53	DDW
7	Male	Poly	28	AT
8	Male	Poly	46	MC
9	Male	Alcohol	63	CCW

Treatment facility: clinical continuation ward (CCW), outpatient treatment (OT), forensic psychiatric addiction care (FPAC), reintegration training (RT), double diagnosis ward (DDW), motivational center (MC) and ambulatory treatment (AT).

finances. Finally, the patients were troubled by health-related issues. Table 1 shows the sample characteristics of the interviewed individuals.

Procedure

Patients were interviewed by an independent trained interviewer, a student working on a Master's degree in mental health who had frequent consultations with her supervisors. Interviews were audiotaped for later transcription. A topics list was used so that the following themes were included in the interviews: the perceived link between SUD and PTSD, the perceived reasons for first substance use and continued substance use, the perceived link between trauma and craving and relapse, and preferred treatment. The interviewer, who was familiar with the organization, was instructed to ask open-ended questions and to approach the participants with a natural curiosity and respect to ensure honest and frank answers.

Each semi-structured in-depth interview lasted approximately 45 minutes. When a participant gave answers outside the scope of the interview, the interviewer brought the conversation back to the subject. At the end of the interview, patients were debriefed and given information about PTSD and treatment options. An independent co-worker transcribed each interview.

Patients gave informed consent for study participation. Patients received gift vouchers worth €20 in exchange for their participation. Ethical approval for this study was given by the Ethical Committee Psychology (ECP) of Maastricht University.

Data analysis

We analyzed the data in a similar way as in our previously published study (Gielen et al., 2014). We used content and inductive analysis to analyze the qualitative data (Pope et al., 2000). We read the interview transcripts and added marginal notes (primarily open codes). Whatever came up and fitted the text segment was written in the side-line. When, for example, the interviewee talked about the fact that he preferred a female therapist, the words "gender clinician" were written in the margin.

After we completed this analysis for all the interviews, we chose sensitizing concepts that reflected associations in the marginal notes between the interviews. The sensitizing concepts were: (1) reasons for continued substance use, (2) connection trauma – substance use, (3) craving, (4) relapse, (5) trauma treatment, (6) consequences of trauma, (7) ages of trauma and first substance use, (8) reasons for first substance use, (9) course of substance use, (10) type of trauma, (11) PTSD symptoms, and (12) symptom decrease after substance use.

For each interview, we created a new document with the concepts as headings and pasted exact copies of the respective text fragments below. We summarized the text fragments; each fragment resulted in a one- or two-sentence summary. In this phase, we combined concepts 2 and 12, as well as concepts 6 and 11. These summaries were then combined for all interviews, resulting in 10 documents with all the summaries for each theme. The summaries were carefully checked for connections and a higher level of abstraction was reached, with six new subcategories emerging. These final categories were: (1) first substance use, (2) course of SUD, (3) motives for continued substance use, (4) craving and relapse, (5) link between SUD and PTSD, and (6) treatment preferences.

To account for a potential researcher effect, the transcribed interviews were independently analyzed by two different investigators (i.e., investigator triangulation). The first author analyzed the data as outlined in this section, while the third author analyzed the data using Kleinman's (1980) clinical core functions as the guiding principle. Although the two investigators used different analysis techniques, they came up with comparable results and conclusions.

Results

First substance use

Analysis of the interviews showed that SUD/PTSD patients often started using alcohol/drugs as teenagers. They described no stress- or trauma-related triggers; first substance use occurred without any provocation and was seen as part of experimenting in one's youth. Some stressed that their first substance use happened in a social environment. For instance: "I started using hashish around age 15 or 16. ... I just did it, I didn't really think about it."

Course of SUD

SUD/PTSD patients described how their substance use gradually increased. They often started using cannabis or alcohol, and then tried other drugs. This phenomenon relates to the gateway theory in which less deleterious drugs pave the way for the use of more dangerous drugs (Vanyukov et al., 2012). It is important to note that only one respondent identified trauma as a deteriorating factor. The other patients described diverse factors that caused an increase in their substance use (e.g., receiving the monthly salary, working as a prostitute, burn-out, change in the family situation, house parties, withdrawal, friends who used substances). Factors related to improvement and abstinence were pregnancy, military service, and health problems.

It became more when I was 18 because of the house parties. We drank, sniffed, smoked, and used XTC really hard. When I joined the army it was over. ... After military service, I met a friend who used heroin and I started using it too.

Motives for continued substance use

Patients were asked to elaborate upon their reasons or motives for substance use. Their motives can be divided into social motives (e.g., social pressure, belonging, parties, coziness, less social anxiety), addiction-specific motives (e.g., withdrawal, loss of control, substance cues, obsessive behavior, taste and smell), expansion motives (e.g., expanding one's consciousness), enhancement motives (e.g., kick, reward, the feeling, opportunism, euphoria, boredom alleviation), and coping motives. Motives in this last category were most frequently reported. Respondents used drugs or alcohol to forget, to escape reality, to survive, to cope with difficulties, to feel safe, to have more self-confidence, to dampen negative emotions, or to be able to sleep, rest, or relax. Some of the respondents mentioned these coping motives in specific relation to trauma, while others seemed to generalize it to all negative emotions and thoughts.

I drank to stop my negative feelings and to not be burdened by them. I don't allow myself to feel anything and I use alcohol as a means to get rid of my feelings.

Opinions regarding the link between craving and relapse and trauma

Patients were asked about their experiences with craving and relapse. They stated that cravings could happen after drug or alcohol cue exposure or during withdrawal. Some SUD/PTSD patients specifically mentioned that cravings occurred when they were confronted with trauma cues (e.g., intrusions): "Memories and nightmares precede my cravings."

Relapse was described as a conscious choice, something that was usual and that could happen at any moment after a period of abstinence. They described specific reasons for relapse, which matched the motives for continued substance use and had a clear focus on coping motives. Other reasons for relapse were the end of a pregnancy and revenge after relationship problems. Patients stated that the chance of another relapse became higher every time they broke their abstinence rule. One patient clearly described his negative thoughts about himself after a relapse: "I'm weak; I'll never get rid of my addiction." Another patient stated:

I continually relapsed because I couldn't forget these people, couldn't forget my problems. I got stuck in using drugs.

Perceived relationship between SUD and PTSD

The interviewed patients clearly described examples of how they self-medicated themselves with drugs or alcohol to cope with the negative consequences of their traumatic pasts. Patients were aware that the positive effects they experienced from drugs and alcohol are superficial and temporary.

When I use, I think about nothing, not about the negative things, the things that happened, the memories... At that moment, I feel great! But it only lasts for a short time and I feel depressed when it's over.

Some patients stated that PTSD symptoms do not diminish during intoxication. It is important to note that some patients only became aware of the link between their traumatic past and their substance use later in their lives. Their substance use typically increased after such a revelation.

Treatment preferences

None of the interviewed patients had been treated for their PTSD. One patient even mentioned that this was the first time in his life that someone had asked about his past traumatic experiences.

When we asked patients what they preferred with regard to the treatment of their PTSD, most replied that they preferred a combination of individual and group treatments. Individual treatment was believed to be easier, more emotion-focused, safer, and more personal. Patients liked the attention they received in individual treatment and the fact that they could discuss more details. They expressed that they could learn more from an in-depth individual approach. Patients had experienced that they were better able to reflect during individual treatment. According to the patients, the ideal individual treatment would take place weekly with a female therapist: someone who is strong and, if possible, a "hands-on" expert. There should be trust and a certain connection between the therapist and the patient. Therapy should not necessarily be solution-focused; patients deemed it more important that the clinician listen, try to understand, confront, and keep on asking questions.

The patients also noted positive aspects of group therapy. These included the fact that group interaction can be very enjoyable, that theoretical knowledge can directly be applied, and that other patients often recognize problems and complaints. The patients pointed to the importance of closed groups and sufficient profundity. A risk of group therapy is that it can be too impersonal.

Analysis of the interviews showed that patients with comorbid SUD/PTSD not only want to confront the trauma, but to discuss daily hassles, like relationship and social problems. Some patients mentioned that medication should be part of the treatment. Others wanted to improve their social and coping skills during treatment. Since the patients believed that trauma treatment is hard and difficult, some of them preferred treatment in a clinical setting. Patients hoped that trauma treatment could give them a new start, teaching them how to enjoy life and feel connected with others. The patients mentioned that they were not fully aware of the benefits of trauma treatment and most of them did not know what kind of trauma treatment is possible. As one patient stated, "I don't know what kind of help you can get."

Another important aspect patients mentioned was that they sometimes live in trauma-prone environments (e.g., with a violent partner). These patients felt that trauma treatment would not help as long as their surroundings did not change.

Although most patients favored integrated treatment of SUD and PTSD in which the person as a whole can be treated instead of only the addiction, some patients did have hesitations. They felt that trauma treatment would not change anything or they felt that there was no need for it, that life goes on. One patient stated: "I want to leave it behind me; I don't want to think about it." Another said:

I don't know, I really don't know. It's so much ... the enormous anxiety. On one hand, I think don't go into it; on the other hand, it keeps triggering me.

Discussion

In this qualitative study, we interviewed SUD/PTSD patients to learn more about their perceptions regarding their comorbidity. We then attempted to answer two research questions.

The first research question concerned the motives of SUD/PTSD patients for starting to use substances and continuing to do so. We noticed an apparent discrepancy in their answers. On the one hand, patients reported that PTSD was not linked with their very first substance use or with aggravation of their substance using pattern; instead, they mainly reported non-trauma-related reasons for starting to use (or using more) substances. On the other hand, all the patients reported self-medicating behavior and craving after trauma intrusions. They declared that coping motives were the most important reasons they used substances and that relapse often happened when they perceived no other means of coping with a difficult situation. These results are in agreement with earlier findings from Ouimette et al. (2007).

However, the self-medicating behavior of SUD/PTSD patients is not limited to coping with trauma-related stress. They also reported using substances to cope with daily hassles and general stressors and to feel more at ease in social environments. Previous researchers who compared the coping styles of SUD patients with and without PTSD found that SUD/PTSD patients are characterized by a maladaptive coping style (Gielen et al., 2015).

Our second research goal was to explore which treatment options SUD/PTSD patients found most feasible. None of the patients were being treated for PTSD and one patient even admitted that no one had ever asked about his traumatic past. This confirms our earlier findings about under diagnosis of PTSD in SUD patients (Gielen et al., 2012, 2014). We further found that patients are well aware of what kinds of treatment they prefer. Most SUD/PTSD patients favor simultaneous treatment of SUD and PTSD that combines individual and closed group treatment, and in which the person as a whole is treated (they judged a primary focus on SUD or PTSD to be insufficient). The patients further expressed a preference for female therapists. Ambulatory treatment was seen as a possibility but it should be possible to switch to in-patient treatment if necessary. Some patients were reluctant to start PTSD treatment, which is understandable in the light of their avoidance symptoms. A final important result was that SUD/PTSD patients knew very little about possible PTSD treatments. Clearly, these two factors (avoiding traumatic memories and lack of knowledge about treatment options) form barriers to

implementing a standard integrated SUD/PTSD treatment for this particular patient group.

Although self-medicating behavior in SUD/PTSD patients seems obvious, it appears more appropriate to use a more complex etiological theory to explain the link between SUD and PTSD. The SUD/PTSD patients said that they did not start using drugs or alcohol because of their PTSD. However, the influence of PTSD on SUD is particularly important in maintaining any addictive behavior. PTSD has to be experienced as instrumental before it reinforces further drug use. More research on this issue is warranted. It would be particularly interesting to examine whether PTSD patients with and without SUD report differences in initial substance use and in the perceived function of the substance use.

Finally, a clear link exists between craving, relapse and PTSD symptoms. SUD/PTSD patients expect a whole-person approach when being treated for their PTSD. The integration of skills training and attention for patients who are fearful of PTSD treatment might further improve SUD/PTSD treatment results.

Declaration of interest

The authors report no conflicts of interest. The authors received no financial support for the research and authorship of this article.

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